STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115482	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossings at East Lake of Journey Llc, The	304 Fifth Avenue Decatur, GA 30030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, staff and resident interviews, record reviews, and review of facility policies titled, Infection Prevention and Control Program, Infection Preventionist, and Enhanced Barrier Precautions, the facility failed to maintain an effective infection prevention and control program. Specifically, the facility failed to ensure staff consistently used the required Personal Protective Equipment (PPE) in accordance with Enhanced Barrier Precautions (EBP) protocols, failed to conduct required infection surveillance audits, and failed to demonstrate staff competency through completed infection control competency checkoffs. The deficient practices created the potential to contribute to the transmission of infectious organisms among residents, staff, and visitors.Findings Include:Review of the facility policy titled Infection Prevention and Control Program revised 3/20/2025, revealed under Policy Explanation and Compliance Guidelines: . 3. a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. 16. a. All staff shall receive training . regarding the facility's infection prevention and control program, including policies and procedures. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.Review of the facility policy titled Infection Preventionist revised 2/1/2024 revealed under Policy Explanation and Compliance Guidelines: . 12. a. Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment. e. Oversight of resident care activities.Review of the facility policy titled Enhanced Barrier Precautions revised January 2026 revealed under Policy Explanation and Guidelines: . 1. a. All staff receive training on enhanced barrier precautions . and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. 2. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: . i. Wounds and/or indwelling medical devices (e.g. feeding tubes .) .3. a. Make gowns and gloves available immediately outside the resident's room. d. The infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. 4. High-contact resident care activities include: . d. Providing hygiene. f. Changing briefs or assisting with toileting.Observation on 1/13/2026 at 3:19 pm revealed Certified Nursing Assistant (CNA) GG provided hygiene care including a brief change to R2 without adhering to required EBP protocols. Despite signage posted on the resident's door indicating required precautions and the availability of PPE outside the room, the CNA entered the resident's room without donning (putting on) a gown while providing direct care to a resident with multiple wounds and receiving tube feeding.Interview on 1/13/2026 at 3: 32 pm with CNA GG confirmed that she did not wear the required gown while providing care to R2. CNA GG stated that she believed the resident did not have a condition that required EBP precautions.Interview and record review conducted on 1/12/2026 at 11:17 am with the Infection Preventionist (IP) revealed the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility failed to maintain documentation of required infection control surveillance and staff competency validation. Specifically, the IP was unable to provide evidence of ongoing audits for critical infection prevention practices, including but not limited to hand hygiene compliance, proper use of PPE, and equipment cleaning and disinfection. The IP produced a total of nine Peri Care/Hand Washing Audit Tool forms completed during a single month of October 2025 for the previous 12 months and stated that no additional infection control audits had been conducted. The IP further stated that she had not been auditing staff and was not aware that routine surveillance auditing was required, questioning whether this was a new expectation. In addition, upon request, the IP was unable to produce any staff infection control competency checkoffs for the previous 12 months. No competency validation documentation related to hand hygiene, PPE use, or other infection prevention practices was provided by the Director of Nursing (DON).Interview on 1/14/2026 at 10:20 am with IP revealed that she expected staff to wear PPE when providing direct contact with a resident who was on EBP.Interview on 1/14/2026 at 10:44 am with the DON revealed that his expectation was for staff to follow established protocols for direct resident care and to use PPE as required. The DON stated that staff were expected to follow their training. The DON further stated that leadership conducted walk-throughs; however, no formal infection control audits were conducted, and no written audit documentation was maintained. The DON stated that CNA competencies were completed during orientation; however, when asked to produce documentation of CNA infection control competency checkoffs, the DON was unable to provide any records.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and review of the facility's policies titled, Baseline Care Plan and Comprehensive Care Plans, the facility failed to ensure that one of 16 residents (R) (R39) using a specialized mattress had a properly functioning air mattress. The deficient practice had the potential to decrease R39's functional ability and healing progress made while in the facility placing her at increased risk for pressure ulcers/ injuries.Findings include:During a review of the facility's policy titled Baseline Care Plan revised 12/23/2023 revealed under Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Under Policy Explanation and Guidelines: .2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such As for IV therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented in the designated format.During a review of the facility's policy title, Comprehensive Care Plans revised 3/20/2025 revealed under Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a residence medical, nursing, and mental and psychosocial needs and all services that are identified in the residence comprehensive assessment and meet professional standards of quality. Under Policy Explanation and Guidelines:1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma informed care as indicated. 3. Comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the residence highest practicable physical, mental, and psychosocial well-being.During a review of R39's facility's admission records revealed diagnoses that include but not limited to schizoaffective disorder, bipolar type acute and chronic respiratory failure with hypoxia, morbid (severe) obesity with alveolar hypoventilation, obstructive sleep apnea, chronic pain syndrome, shortness of breath, dependence on supplemental oxygen, depression, unspecified, insomnia, unspecified, posttraumatic stress disorder, chronic.During a review of R39's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. Section GG (Functional Abilities and Goals) revealed the need for maximum assistance with all Activities of Daily Living (ADLs) care needs. Section M (Skin Conditions) revealed the risk of developing pressure ulcers/ injuries.During a review of R39 care plan revealed, Requires assistance (assist) with ADL's related to (r/t) weakness, decreased mobility, pain. She requires the assist of one with ADLs. She is able to participate in her care. The amount of assist may vary from day to day. Staff will adjust and assist. Pressure reducing cushion to wheelchair. Refer to therapy as needed. Weekly skin assessment by licensed nurses.During a review of the facility's Service Task Detail document revealed that the service order for R39's air mattress was not placed until 1/12/2026 at 3:05 pm, and that the second order for a replacement mattress was placed on 1/13/2026 at 6:06 pm.A review of the facility's Active Rentals list revealed that R39 was originally ordered and was in use of a [NAME] 1B 42 air mattress and that the facility ordered her a Air Force 1000 Plus 42 air mattress on 1/13/2026.The initial observation/ interview on 1/11/2026 at 1:23 pm with R39 revealed her stating that her air (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mattress had been broken since 1/9/2026 and they can't fix it. She stated that she is in a lot of pain due to mattress being deflated and was currently resting on the metal base of the bed. R39 stated that the staff was aware as she informed the staff immediately. She stated that the recreation staff had attempted to fix the issue without success and was told that there was no one to look at it till Monday. R39 denied being offered another bed until her bed was fixed.Observation/ interview on 1/12/2026 at 2:07 pm revealed R39s air mattress deflated with her still in bed lying on the it without any barrier between her mattress and the metal frame. She stated that she was told that a part needed to be ordered for the mattress and it would arrive tomorrow, 1/13/2026. She denied being offered another mattress for the time being.Observation/ interview on 1/13/2026 at 12:00 pm revealed that R39 was in bed with the deflated air mattress still in place. She again denied being offered a change of mattress or temporary mattress until the part came in. She stated that she was having a lot of back pain due to the mattress and asked if the nurse could be called to administer pain medication.During an interview on 1/13/2026 at 12:17 pm with the Activities Director revealed that she was made aware of the deflated air mattress by R39 on 1/9/2026 and immediately informed the nursing staff after attempting to fix it without success. She stated that she again attempted to fix the mattress on 1/12/2026 without success and that R39 was complaining of pain in her back. She stated that she again informed the nurse and was told that administration was aware and already addressing it.An observation/interview on 1/13/2026 12:23 pm with the Director of Nursing (DON) revealed that he was made aware of the bed being broken on 1/11/2026 and had been in communication with the rental company. He stated that he was informed by the rental company that the part to fix the bed had to be ordered and was expected to be delivered on 1/12/2026 but never arrived. He denied being aware of R39 being offered another mattress or change in bed until the part arrived. He admitted that R39 should have been offered another mattress and stated that he would follow up with the company on the delivery.An interview on 1/14/2026 at 12:11 pm with the Administrator and the DON revealed that the part for R39's mattress did not arrive and that the company was contacted. The Administrator stated that the company informed him that they did not have the same mattress available but had something similar for the time being. The DON stated that they convinced R39 to use the rental until her regular air mattress became available.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and review of the facility policy titled, Resident Assessment - Coordination with PASARR Program Date Reviewed/ Revised:12/24/2023 the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level two was submitted for two of 21 residents (R) (R3 and R69) reviewed for PASARR II. This deficient practice had the potential to place R3 and R69 at increased risk of not receiving required behavioral health support to meet their daily needs.Findings include:Review of the facility policy titled Resident Assessment - Coordination with PASARR Program, dated 12/24/2023 revealed under Policy: This facility coordinates assessments with the Preadmission Screening and Resident Review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or related condition receive care and services in the most integrated setting appropriate to their needs. Under Policy Explanation and Compliance Guidelines: All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid screening rules. a. PASARR Level I is the initial pre-screening completed prior to admission. i. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. A positive Level I screen requires a PASARR Level II evaluation prior to admission. 5. b. PASARR Level II is a comprehensive evaluation completed by the appropriate stateˆdesignated authority (not by the facility). It determines whether the individual has a mental disorder, intellectual disability, or related condition, identifies the appropriate setting for the individual, and recommends any specialized or rehabilitative services needed. If a resident was not screened due to an approved exception and remains in the facility longer than 30 days: b. The Level II resident review must be completed within 40 calendar days of admission.1. Review of the electronic medical record (EMR) revealed that R3 was admitted with pertinent diagnoses including, but not limited to, postˆtraumatic stress disorder, depression (unspecified), persistent mood (affective) disorder (unspecified), suicidal ideations, and generalized anxiety disorder. Review of R3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating R3 was cognitively intact. Section I (Active Diagnoses) revealed anxiety disorder, malnutrition, postˆtraumatic stress disorder (PTSD).Review of R3's care plan dated 7/31/2025 indicated a problem that R3 exhibits behaviors related to suicidal ideations. He is in a depressed mood and is sad about being away from family and his recent admission to the nursing facility. He stated that he does not have a plan but thinks about it. Goals included that R3 will have fewer episodes of behavior by the review date. Interventions included administering medications as ordered and monitoring for side effects and effectiveness, assisting the resident in developing more appropriate coping methods, and encouraging the resident to express feelings appropriately. Caregivers are to provide opportunities for positive interaction and attention, stopping to talk with him when passing by. Behavioral services are to be consulted as needed. Focus: R3 uses psychotropic medications related to psychiatric conditions, mood, depression, and suicidal ideations. Goal: The resident will remain free of psychotropic drugˆrelated complications, including movement disorders, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through the review date. Interventions: Administer psychotropic medications as ordered by the physician. Consult with pharmacy and the physician to consider dosage reduction when clinically appropriate, at least quarterly. Discuss with the physician and family the ongoing need for the medication. Review behaviors, interventions, and alternate therapies attempted and their effectiveness per facility policy. Educate the resident, family, and caregivers about risks, benefits, and potential side effects or toxic symptoms. Monitor and record occurrences of target behavior symptoms and document per facility protocol. Review of the Physician's Orders for R3 included but (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not limited to: Order dated 1/10/2026: Mirtazapine Tablet 15 mg. Give 1 tablet by mouth once daily for generalized anxiety and insomnia. Order dated 11/20/2025: Hydroxyzine HCl Oral Tablet 25 mg. Give 1 tablet by mouth twice daily for anxiety. Order Note dated 1/12/2026: The order for Mirtazapine Tablet 15 mg, 1 tablet by mouth once daily for generalized anxiety and insomnia, triggered drug protocol alerts/warnings for a drugˆtoˆdrug interaction.During an interview on 1/12/2026 at 2:13 pm with Social Services (SS), she stated she was not certain whether R3 had a PASARR Level II and confirmed that R3's name was not on the PASARR list.During a followˆup interview on 1/13/2026 at 10:20 am, Social Services confirmed that after reviewing R3's medical records, R3 did have diagnoses that qualified for a PASARR Level II, but it had not been submitted.During an interview on 1/14/2026 at 11:12 am with the Director of Nursing, it was clarified that the PASARR Level II assessment was used to determine a resident's mental status. This responsibility typically falls under Social Services. 2. Review of the EMR revealed R69 was admitted with pertinent diagnoses including, but not limited to, postˆtraumatic stress disorder (unspecified) and major depressive disorder.Review of R69's quarterly MDS assessment dated [DATE] revealed BIMS score of 15, indicating R69 was cognitively intact. Section D (Mood) revealed little interest or pleasure in doing things; feeling down, depressed, or hopeless; trouble falling or staying asleep or sleeping too much; and feeling tired or having little energy. Section E (Behavior) indicated no behaviors exhibited. Section N (Medications) indicated antidepressant medication use. Section I (Active Diagnoses) also revealed depression and postˆtraumatic stress disorder (PTSD).Review of R69's care plan dated 4/30/2025 indicated a problem that R69 is under the age of 55 and at risk for social isolation. The goal was for the resident to make a positive adjustment with peers through the next review. Interventions included encouraging family visits, encouraging the resident to engage in activities of interest, and providing emotional support and supportive counseling as needed.Review of the Physician's Orders for R69 included but was not limited to: Order dated 1/8/2026: Trazodone HCl Tablet 50 mg. Give 1 tablet by mouth once daily for insomnia/depression. Order dated 1/7/2026: Escitalopram Oxalate Tablet 5 mg. Give 1 tablet by mouth once daily for depression.During an interview on 1/12/2026 at 2:13 pm, Social Services revealed that there was no PASARR Level II for R69, as she was not aware of his diagnosis of PTSD.During a followˆup interview on 1/13/2026 at 10:20 am, Social Services confirmed that after reviewing R69's medical records, R69 did have the diagnosis to qualify for a PASARR Level II, but it had not been submitted.During an interview on 1/14/2026 at 10:32 am, R69 stated he would benefit from additional services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and a review of the facility's policy titled, Activities of Daily Living (ADLs), the facility failed to ensure one of 42 sampled residents (R) (R13) who was unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and good hygiene. This failure had the potential to decrease R13 self-esteem and contribute to psychosocial distress.Findings include:During a review of the facility's policy titled Activities of Daily Living (ADLs) revised 3/20/2025 revealed under Policy: The facility will, based on resident's comprehensive assessment and consistent with the resident's needs and choices, ensure our residents abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. Under Policy Explanation and Compliance Guidelines: . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Review of the facility's admission records for R13 revealed diagnoses that included but not limited to peripheral vascular disease, longstanding persistent atrial fibrillation, chronic kidney disease, stage 3, type 2 diabetes mellitus without complications, heart failure, acquired absence of left leg below knee, chronic obstructive pulmonary disease, cognitive communication deficit, depression and need for assistance with personal care.Review of R13's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive decline. R13 requires maximal assistance with all ADL care needs.Review of the care plan for R13 revealed a focus area of ADLs: Requires assistance (assist) with Activities of Daily Living debility, decreased mobility, pain, self-care deficit, weakness. He requires the assist of one for ADLs. He is able to participate in his care. Resident will have care needs met daily with assistance of staff as needed. Bed Mobility - staff assistance as needed. Assist as needed with shower twice weekly or per resident preference. Assist resident as needed with proper body alignment while in bed as needed. Continence - assist with incontinent care. Eating: Staff assistance as needed. Encourage resident to participate to the fullest extent possible with each interaction; praise resident for effects and success. Encourage choices with care. Monitor and report changes in physical functioning ability and in ROM ability. Nail care PRN (as needed). Personal Hygiene - Staff assistance as needed. Staff to assist with completion of ADL's on a daily basis. Therapy to eval and treat as indicated. Toilet use: Staff assistance as needed. Use Mechanical Sit to Stand Lift x2 staff assistance for transfer. During an initial observation and interview on 1/11/2026 at 12:17 pm revealed R13 fingernails with a buildup of black/ dark brown substance under the nails and each nail was long and unkempt. R13 stated it's been over a month since they were cleaned or cut, and it needs cutting.Observation on 1/12/2026 at 9:09 am revealed R13's fingernails had not been addressed. Nails remained long and unkempt with black/ dark brown substances packed underneath each nail on both hands. Observation completed on 1/13/2026 at 1:29 pm accompanied by the Director of Nursing (DON) revealed R13's fingernails remained dirty with black/ dark brown substance underneath each nail, all nails long and uneven. The DON confirmed the findings and stated that there is no reason for it to be like this, I will take care of it immediately. He revealed that it was the Certified Nursing Assistant's (CNA) job to ensure resident's grooming was completed with ADL care.An interview on 1/14/2026 at 9:48 am with CNA AA revealed that R13 had on occasion requested to have his nails cleaned and cut. She revealed that she had cleaned and cut his nails in the past but not recently. She stated that sometimes due to R13 being in pain or having swelling in his hands, she did not do nail care often. She denied reporting this to the nurse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Accidents and Supervision, the facility failed to ensure the environment remained free of accident hazards. Specifically, the facility allowed an electrical appliance capable of producing heat (a clothes iron) to be present and accessible in one resident's (R) (R85) room on a unit that housed residents with wandering behaviors. This deficient practice had the potential to cause burns and fire-related injury.Findings include:Review of the facility policy titled Accidents and Supervision revised 2/1/2024 revealed under Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). Under Identification of Hazards and Risks: The process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff . are to be involved in observing and identifying potential hazards in the environment . b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.Review of the electronic medical record (EMR) revealed R85 was admitted to the with diagnoses including but not limited to right-sided hemiplegia and hemiparesis following a cerebral infarction, epilepsy, unspecified convulsions, aphasia and fluency disorder following cerebral infarction, generalized muscle weakness, and major depressive disorder.Review of R85's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R85 was cognitively intact. Section GG, functional status, revealed R85 was impaired to one side requiring supervision or touching assistance with Activities of Daily Living (ADLs).Review of R85 care plan dated 1/11/2026 indicated a problem of risk for injury due to decreased mobility, need for staff assistance with ADLs, seizure disorder, communication impairment, fall risk, and smoking-related hazards. Goals included but not limited to remaining free from injury, maintaining safe transfers and bed mobility, being able to communicate basic needs, and avoiding burns or fire-related injuries. Interventions included but not limited to assisting with ADLs as needed, observing the resident while shaving, providing staff supervision during transfers and bed mobility, implementing seizure precautions, ensuring a safe environment with call light in reach and bed in lowest position, monitoring for signs of burns or unsafe smoking practices, and documenting changes in physical functioning.Review of the Physician Orders for R85 included but was not limited to:Order dated 6/20/2025 for behavior monitoring: monitor and document behaviors, number of episodes, interventions, outcomes, and side effects every shift due to verbal aggression, anxiety, depression, agitation, and other behavioral concerns. Interventions include redirection, environment changes, diversion, toileting, and setting limits. Order dated 11/10/2025 for behavioral intervention: resident frequently displays verbal aggression; interventions include moving to a calmer environment and verbal redirection. Document any acute changes or difficulty with redirection. Order dated 11/12/2025 for Topiramate 50 mg BID (twice a day): administer as prescribed for seizure management, observe for seizure activity, implement seizure precautions.Order dated 11/12/2025 for Lexapro (escitalopram) 20 mg daily: monitor mood and behavior, administer as prescribed.Order dated 12/10/2025 for Buspirone 5 mg BID (twice a day): monitor anxiety and behavioral symptoms, administer as prescribed.Order dated 12/20/2025 for Trazodone 100 mg nightly: administer as prescribed for mood support, monitor for sedation or behavioral side effects.Observation on 1/11/2026 at 1:50 pm with R85 in his room revealed a clothes iron, plugged in, positioned on the windowsill next to his bed.Observation on 1/12/2026 at 12:12 pm of R85's room confirmed that the clothes iron remained on the windowsill beside his bed. Observation and interview on 1/12/2026 at (continued on next page)

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	115482	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossings at East Lake of Journey Llc, The	304 Fifth Avenue Decatur, GA 30030

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:50 pm with R85, in the presence of Licensed Practical Nurse (LPN) II, verified the presence of a clothes iron on the windowsill. R85 stated that the iron was functional and that he used it to iron clothes on top of his bed. He also stated that staff were aware of the iron.Review of R85's progress notes dated 1/12/2026 revealed a care plan meeting conducted with R85 and his sister regarding acceptable equipment for resident use, safe practices, and inventory of personal belongings.Interview on 1/12/2026 at 1:54 pm with LPN II revealed that she denied being aware that resident had a clothes iron and did not notice it positioned on the windowsill.Interview on 1/12/2026 at 2:15 pm with the Director of Nursing (DON) revealed that he was not aware that R85 had a clothes iron in his room. Follow-up interview at 3:17 pm confirmed that the clothes iron was removed from R85's room and placed in the DON's office. The DON reported that staff had been in-serviced regarding hazardous items, a facility-wide audit of resident rooms is being conducted, and a list of residents who wander is being compiled. The DON also confirmed that R85's family did not provide the iron.